Minnesota Multistate Contracting Alliance for Pharmacy Facility Membership Application

The completed form must be returned to the State Contact for authorization. The State Contact will then forward the authorized form to the MMCAP office for processing.

#Which contracts will this facility use? Check all that apply. #PharmaceuticalFlu VaccineHospital & Medical Supplies *Facility Name:* *On-site purchasing contact person:* *Title:*Phone:*Fax: *E-mail Address:* *Street Address (include P.O. Box if applicable):* *City:*State:*ZIP:* *DEA number:*HIN number:* *Average purchases of pharmaceutical per month: \$ Please check the phrase that best describes your facility:	The statutory addressity under wit	ich this facility	may purchase goods	from state contracts is:
PharmaceuticalFlu VaccineHospital & Medical Supplies *Facility Name: *On-site purchasing contact person: *Title: *Phone: *Fax: *E-mail Address: *Street Address (include P.O. Box if applicable): *City: *State: *ZIP: *DEA number: *HIN number: *Average purchases of pharmaceutical per month: \$ Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Department.			(give specific st	atutory citation).
*Facility Name: *On-site purchasing contact person: *Title: *Phone: *Fax: *E-mail Address: *Street Address (include P.O. Box if applicable): *City: *State: *Average purchases of pharmaceutical per month: Please check the phrase that best describes your facility: Correctional Facility *Community Health Department of the purchase of the phrase that best describes your facility: *Public/Community Health Department of the purchase of the purchase of the phrase that best describes your facility:	Which contracts will this facility	use? Check all	that apply.	
*On-site purchasing contact person: *Title: *Phone: *Fax: *E-mail Address: *Street Address (include P.O. Box if applicable): *City: *State: *ZIP: *DEA number: *HIN number: *Average purchases of pharmaceutical per month: \$ Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Department.	✓ PharmaceuticalFl	u Vaccine	Hospital & Medi	cal SuppliesALL THR
*Title:*Phone:*Fax:* *E-mail Address:* *Street Address (include P.O. Box if applicable):* *City:*State:*ZIP:* *DEA number:*HIN number:* *Average purchases of pharmaceutical per month: \$ Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Department.	Facility Name:			
*E-mail Address:*Street Address (include P.O. Box if applicable):*City:*State:*ZIP:**DEA number:*HIN number:**Average purchases of pharmaceutical per month: \$*Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Department.	On-site purchasing contact person	on:		
*Street Address (include P.O. Box if applicable): *City: *State: *ZIP: _ *DEA number: *HIN number: *Average purchases of pharmaceutical per month: \$ Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Departments	*Title: *Phone:		*Fax:	
*City: *State: *ZIP: _ *DEA number: *HIN number: *Average purchases of pharmaceutical per month: \$ Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Department	E-mail Address:			
*Average purchases of pharmaceutical per month: \$	Street Address (include P.O. Bo	ox if applicable):	
*Average purchases of pharmaceutical per month: \$	City:		*State:	*ZIP:
Please check the phrase that best describes your facility: Correctional Facility Public/Community Health Department	*DEA number:		*HIN number:	
Correctional Facility Public/Community Health Departm	Average purchases of pharmace	utical per mon	th: \$	
•	lease check the phrase that best of	describes your f	facility:	
M . III M T E T	Correctional Facility		Public/Community	Health Department
Mental Health Treatment Facility Oncology Center	Mental Health Treatment Fac	cility	Oncology Center	
Acute Care Hospital Nursing Home	Acute Care Hospital		Nursing Home	
Student Health Service Veterinary School	Student Health Service		•	
Community Health Clinic Facility Other (describe)	Community Health Clinic Fac	cility	Other (describe)	
*Size of Facility: Beds *Annual Clinic Visits *Annual Rx's	•			

MMCAP Fax: 651-297-3996

Barbara Rhodes, MMCAP LA State Contact

Tel: 225-342-8035 · E-mail: brhodes@doa.state.la.us

Signed:

Date: _____